STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 01 B. WING	02/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000				
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/06/12 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Lowell Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was built as a two story building over a partial basement with a two story	K0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 3/7/12.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	addition offset and connected to the original structure by a stairway. The construction was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in only the first floor east resident rooms. The facility has a capacity of 90 and had a census of 66 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/10/12. The facility was found not in compliance with the aforementioned requirements as evidenced by:			

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to ensure 2 of 12 doors to hazardous areas, such as a laundry larger than 100 square feet would self close. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects 6 staff observed in the basement service area. Findings include: Based on observation with the maintenance supervisor and administrator on 02/06/12 at	K0029	K029 The two laundry room doors were replaced to ensure they close automatically and latch. All doors to hazardous areas will be adjusted to ensure they close automatically and latch. The Maintenance Director has been in-serviced to check all door closures monthly with his preventative maintenance checks. The Executive Director will round with the Maintenance Director to ensure all doors to hazardous areas automatically close and latch. Upon verifying all doors close and latch, the Maintenance Director will monitor all doors daily for 1 week then monthly on the PM logs. The Executive Director will sign off on the PM logs to ensure completion monthly. Completion date = 3/7/12	03/07/2012

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	3:35 p.m., two self closing doors to the laundry were equipped with self closing devices which failed to close the doors into their door frames. The maintenance supervisor acknowledged at the time of observations the door closers needed adjustment to ensure they would close the doors completely. 3.1-19(b)			

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K0034 SS=E	Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 3 exit stairways was separated from an enclosed usable space by the two hour fire resistance of the stairway exit enclosure. The exception to LSC 7.2.2.5.3 permits enclosed usable space under stairs, provided that the space is separated from the stair enclosure by the same fire resistance as the stair enclosure. This deficient practice affects visitors, staff and 30 or more residents on the second and third floors who might use the east stairway for evacuation. Findings include: Based on observation with the maintenance supervisor and administrator on 02/06/12 at 3:20 p.m., a storage enclosure was located under the east stairway at the basement level. The open door separating the storage enclosure and the exit stairway left a two inch gap between the storage room and stairway. The maintenance	K0034	K034 The storage door in the basement stairwell was adjusted to eliminate the gap. All storage doors in the facility were inspected to ensure there were not any gaps between the door and the door frame. All problems identified were addressed. The Maintenance Director has been in-serviced to check all storage doors monthly to ensure there are not any gaps. The Executive Director will round with the Maintenance Director to ensure any gaps between the door and the door frame are eliminated. Upon verifying all gaps are eliminated, the Maintenance Director will monitor all doors daily for 1 week then monthly on the PM logs. The Executive Director will sign off on the PM logs to ensure completion monthly. Completion date = 3/7/12	03/07/2012

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	supervisor agreed at the time of observation, the open door could not resist fire for two hours from within the storage enclosure. 3.1-19(b)			

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K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 fire doors on the basement level was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff, and 30 or more residents on the second and third floors who might use the east stairway for evacuation. Findings include: Based on observation with the maintenance supervisor and administrator on 02/06/12 at 3:30 p.m., one door in the fire door set separating the basement level and east stairway could not latch. The original fire door	K0044	K044 Latching hardware was added to the basement door to allow the door to latch. All fire barrier doors will be adjusted to ensure they close automatically and latch. The Maintenance Director has been in-serviced to check all fire barrier doors monthly to ensure they latch properly when he performs his preventative maintenance checks. The Executive Director will round with the Maintenance Director to ensure all fire barrier doors automatically close and latch. Upon verifying all doors close and latch, the Maintenance Director will monitor all doors daily for 1 week then monthly on the PM logs. The Executive Director will sign off on the PM logs to ensure completion monthly. Completion date = 3/7/12	03/07/2012

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	latching hardware had been removed and a door knob put on the door which did not include any latching mechanism. The maintenance supervisor acknowledged at the time of observation, the fire door had been changed. 3.1-19(b)			

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K0051 SS=E	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system in 1 of 7 smoke compartments was properly separated from an air supply. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 6 residents on the second floor. Findings include:	K0051	K051 A metal divider was placed between the smoke detector and the air vent on the second floor. All smoke detectors were inspected to ensure they are not near an air vent. All problems identified were addressed. The Maintenance Director has been in-serviced to ensure smoke detectors are not near an air vent. The Executive Director will round with the Maintenance Director to ensure there are not any smoke detectors near an air vent. Upon verifying there are not any smoke detectors near an air vent, the Maintenance Director will monitor all smoke detectors daily for 1 week then monthly on the PM logs. The Executive Director will sign off on	03/07/2012

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	Based on observation with the maintenance supervisor and administrator on 02/06/12 at 3:15 p.m., a corridor smoke detector was located 24 inches from an air vent near room 205. The maintenance supervisor confirmed the distance measurement at the time of observation, and acknowledged the air flow could impede the function of the smoke detector. 3.1-19(b)		the PM logs to ensure completion monthly. Completion date = 3/7/12	

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K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
	Based on record review, interview and observation; the facility failed to ensure sprinkler heads providing protection for 2 of 7 smoke compartments were maintained. This deficient practice could affect staff, visitors and 10 or more residents in the main dining room adjacent to the kitchen and 34 residents on the third floor . Findings include: Based on review of the automatic Sprinkler System Inspection Report dated 08/10/11 with the maintenance supervisor and administrator on 02/06/12 at 12:15 p.m., concerns about the condition of sprinkler heads were noted by the inspection contractor including: "6 sprinkler heads in kitchen showing corrosion should be replaced to assure activation, South hall 3rd floor east corr. one head needs to be moved to center of tile. too close to light, there are also a few heads that need to	K0062	K062 All sprinklers heads have been replaced, moved, or adjusted. All reports from the last year related to the fire system have been reviewed to ensure all recommendations have been followed. The Maintenance Director has been in-serviced to follow through on all recommendations after an inspection on the fire or sprinkler system. The Executive Director will round with the Maintenance Director to ensure all recommendations have been addressed. The Executive Director will review all inspection reports and initial them to ensure the facility has addressed any recommendations. Completion date = 3/7/12	03/07/2012

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	be adjusted to proper ceiling height, need to pull 2 chrome (plastic) wall plates (split)." The record noted the maintenance supervisor "would like them all (noted sprinklers) replaced." The maintenance supervisor said at the time of record review, nothing had been corrected. There was no evidence of new sprinkler heads or other changes made during the tour with the administrator and maintenance supervisor on 02/06/12 between 1:30 p.m. and 4:30 p.m. 3.1-19(b)			

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K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the discharge for 1 of 5 first floor exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 18 resident using the southeast exit from the first floor. Findings include: Based on observation with the maintenance supervisor and administrator on 02/06/12 at 2:00 p.m., the concrete exit discharge surface for the southwest exit from first floor was cracked. The concrete pad outside the exit had a one inch change in the level between the adjacent surface over which	K0038	K038 The concrete was grinded down to minimize tripping hazards. All fire exits were inspected to ensure all tripping hazards were minimized. The Maintenance Director has been in-serviced to check all fire exits monthly to ensure they are free from trip hazards. The Executive Director will round with the Maintenance Director to ensure any tripping hazards in fire exits are eliminated. Upon verifying all tripping hazards are eliminated, the Maintenance Director will monitor all exits daily for 1 week then monthly on the PM logs. The Executive Director will sign off on the PM logs to ensure completion monthly. Completion date = 3/7/12	03/07/2012

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	anyone would travel making the surface uneven and a trip hazard. The maintenance supervisor said at the time of observation, the damage was weather related. 3.1-19(b)			

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K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned by properly trained and qualified people. NFPA 96 section 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person. This deficient practice could affect kitchen staff, and 10 or more visitors and residents in the main dining room. Findings include: Based on record review with the administrator and maintenance supervisor on 02/06/12 at 12:40 p.m., kitchen exhaust hood and duct cleaning was performed by	K0069	K069 The kitchen exhaust system was cleaned by a trained and qualified person. There are not any other kitchen exhaust systems in the facility. The Maintenance Director has been in-serviced to ensure the kitchen exhaust system is cleaned by a trained and qualified person. A contract has been signed with a trained and qualified professional to have the kitchen exhaust system cleaned twice a year. The Maintenance Director will monitor the cleaning of the kitchen exhaust system monthly on the PM logs. The Executive Director will sign off on the PM logs to ensure completion monthly. Completion date = 3/7/12	03/07/2012

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	the maintenance supervisor on 11/23/11. The maintenance supervisor acknowledged at the time of record review, he lacked any formal training or certification for the cleaning and there was no other documentation the entire system was inspected by a properly trained, qualified, and certified company or person. 3.1-19(b)			